STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	008899	A. BUILDING: _____ B. WING _____	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL NORTHWEST INDIANA	5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320

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S 000	INITIAL COMMENTS This visit was for investigation of a State hospital complaint. Complaint Number: IN00155117 Substantiated: deficiency related to allegations is cited. Date: 10/9/14 Facility Number: 008899 Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor QA: claughlin 10/21/14	S 000		
S 930	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, observation, and personnel interview, nursing staff failed to supervise and evaluate the nursing care for each patient related to inconsistent wound documentation and lack of daily nursing documentation 1 of 5 (Patient #1) closed patient medical records reviewed and lack of call light within reach for 1 of 1 (Patient #6) patient's interviewed while on tour.	S 930		11/10/14

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S 930	Continued From page 1 Findings: 1. Policy No.: H-WC 02-001 PRO titled "HD Manual Skin & Wound Care", revised/reapproved 2/2014, indicated on pg. 1, under Procedure section, points 1. and 2., "RN will complete a wound assessment at the time of admission. An initial assessment of major wounds by the Wound Care Coordinator / designee will be provided within 48 hours of the admission date, weekly follow up, new wounds, and within 48 hours prior to discharge...identify the location, measure the largest and smallest, photograph, and document...all wounds with an etiology of pressure/shear must be assessed and documented individually." 2. Policy No.: HD WC 01-001 titled "Prevention and Treatment of Pressure Ulcers and Non-Pressure Related Wounds", revised/reapproved 2/2014, indicated on pg.: A. 3, under Prevention Components section, point 3., "The skin assessment and inspection for pressure ulcers and non-pressure related skin issues shall include: a. Full assessment of skin is completed on admission and at designated intervals throughout the patients stay. b. Modified skin assessments may be completed during routine care." B. 4, under Treatment Components section, point 1., "Identification of pressure and non-pressure related wound characteristics initially, at regular intervals, as needed with change in wound status and on date of discharge; document findings using the Bates-Jensen Wound Assessment Tool." 3. Policy No.: H-IM 02-001 titled "General Documentation Guidelines", revised/reapproved	S 930		

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S 930	Continued From page 2 8/2012, indicated on pg. 1, under Policy section, points 1. and 2., "The hospital initiates and maintains a medical record for every individual assessed, cared for, treated, or served...Documentation in the medical record is detailed, organized, and contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers." 4. Review of closed patient medical records on 10/9/14 at approximately 1117 hours, confirmed patient #1 MR was a 73-year-old who was admitted to the facility on 7/10/14 for deconditioning and long-term antibiotic therapy: A. skin assessment on Nurse to Nurse Admission Report dated 7/10/14 was documented as skin not being intact with wound to left buttock and a left hip skin tear. B. on the Daily Nursing Assessment Flowsheet under Skin/Dressings dated 7/10/14 the skin wounds were documented as sacral, right buttocks, and right and left leg (area not indicated). C. on the Daily Nursing Assessment Flowsheet long hand Nurse's Notes dated 7/10/14 the skin wounds were documented as sacral, left buttocks, and right and left leg (area not indicated). D. on Admission Orders dated 7/10/14, wounds were documented as right and left leg (area not indicated). E. on Wound Care Status Report dated 7/11/14, wounds were documented as right lower leg and left lower leg and "multiple bruises on upper extremities, abdomen, bilateral trochanters, all bruises are blanchable with no pain associated." F. on the Daily Nursing Assessment Flowsheet long hand Nurse's Notes dated 7/12/14 at 2200	S 930		

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S 930	Continued From page 3 hours dressings were changed to bilateral lower legs and patient refused dressings to left hip and sacrum. G. there were pictures taken weekly with measurements for the bilateral lower legs during patient's length of stay; but not the left hip, buttocks, or sacrum as required by policy and procedure. H. Daily Nursing Assessment Flowsheets dated from 8/17/14 through 8/22/14 were missing from the MR. 5. Staff #24 (Registered Nurse, R.N., Nurse Manager), was interviewed on 10/9/14 at 1303 hours and confirmed for patient #1 the wound care nurse documented on 7/11/14 that patient had "bilateral trochanters all bruises are blanchable with no pain associated". There was no documentation that patient had a left hip skin tear or pressure ulcer on left buttock. However, a nurse documented on 7/10/14 from nurse to nurse report from transferring hospital to this facility that patient had a left hip skin tear and Mepiplex to left buttock (type of wound not indicated). Then on 7/10/14 at 1600 the nurse documented in Nurses Notes "wound to sacral and wound to left buttock and foam applied". She did not document what side the sacral wound was on or type of wound. These wounds should have been photographed and addressed by the wound care nurse weekly during patient's stay, but there is no documentation of this. Only the patient's right and left lower leg wounds were photographed and addressed by the wound care nurse. The facility did not follow their policy/procedure by not consistently documenting all skin breakdown including identification of pressure and non-pressure related wound characteristics initially, at regular intervals, as needed with change in wound status, and on date	S 930		

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S 930	Continued From page 4 of discharge with photographs, measurements, location, etc. 6. Staff #25 (Wound Care Coordinator), was interviewed on 10/9/14 at 1350 hours and confirmed wound documentation was inconsistent for patient #1. 7. Staff #23 (Clinical Educator), was interviewed on 10/9/14 at 1125 hours and confirmed Daily Nursing Assessment Flowsheets dated from 8/17/14 through 8/22/14 were missing from patient #1's MR. The facility also did not follow their policy/procedure by lacking documentation of Daily Nursing Assessment Flowsheets dated from 8/17/14 through 8/22/14. 8. Policy No.: H-PC 03-006 titled, "Patient Call Devices", revised/reapproved 2/2012, was reviewed on 10/9/14 at approximately 11:55 AM, and indicated on pg.: A. 1, under Procedure section, point 1., "The admission nurse shall: Assure that there is a functional call light easily accessible by the patient. B. 2, under Procedure section, point 6., "When rounding/interacting with the patient staff shall: Verify that the patient's call device is easily accessible for use." 9. On 10/9/14 at 1500 hours, the inpatient unit was toured and patient #6 was interviewed at 1515. Patient #6 confirmed call light was currently not within reach and it was observed to be dangling off the side of patient's bed out of reach. 10. Staff #21 (Director of Quality Management), was interviewed on 10/9/14 at 1520 hours and confirmed patient #6 did not have their call light within reach. The facility did not follow their	S 930		

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S 930	Continued From page 5 policy/procedure by not ensuring a functional call light is easily accessible by patient #6.	S 930		